

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005075	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/04/2015
NAME OF PROVIDER OR SUPPLIER ST VINCENT HOSPITAL & HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>The visit was for investigation of a State complaint.</p> <p>Complaint Number: IN 00174568</p> <p>Substantiated: No deficiency related to the allegations is cited.</p> <p>Facility #: 005075</p> <p>Survey Date: 11/04/15</p> <p>QA: cjl 12/10/15</p>	S 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE